

ACC NEWS

President's Page: Dollars Without the Sense

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"Money makes the world go round" is a phrase that has taken on new meaning these days. Following last September's terrorist attacks, we all witnessed how the financial problems of one industry or group exert a broad ripple effect. Medicine is no different. The financial health of our nation's hospitals and physician practices directly affects many other people and many other groups, from patients to insurers to governments. That said, there is a troubling trend that is engulfing our profession: an increased demand for cardiology services coupled with decreases in reimbursement for those same services. The end result is that physicians are working more and more and being paid less and less to treat increasing numbers of patients.

As doctors, we recognize that reimbursement dollars affect much more than just our standard of living; they equate to patient care. Ensuring that cardiologists are reimbursed at a fair and equitable rate means that our practices will have the necessary funds to treat the more than 60 million people in this country who have coronary and other forms of cardiovascular disease, and the millions more who are at risk. The unfortunate dichotomy this situation presents has placed cardiovascular specialists on our own stress test, one that is testing the upper limits of what we are able and willing to do—and for how much—as physicians.

CMS AND MEDICARE

The embodiment of this fewer-dollars-for-more-work trend was witnessed last November, when the Centers for Medicare and Medicaid Services (CMS) released the final regulation on the Medicare fee schedule for 2002. To say that the 237-page regulation was a shock to many physician groups is an understatement. The average reduction in fees paid to physicians by Medicare was 5.4%. Cardiologists were hit especially hard, with average fee reductions of 8.6% and reimbursement for some procedures, such as angioplasty, echocardiography, and electrophysiology, being reduced by anywhere from 12% to 16%. In my home state of Indiana, the fee schedule reductions would cut \$50 million in payments to physicians—ranking Indiana among the top ten states most affected by the cuts. Combine these cuts with double digit increases in medical malpractice for many physicians, and the situation becomes increasingly dire.

This situation brought to the forefront an important issue. As physicians, we are part of an enormous social and

economic jigsaw puzzle—one in which patients, government bureaucrats, pharmaceutical companies, device manufacturers, elected officials, and many others are all pieces. Physicians, unfortunately, are becoming larger and more worn puzzle pieces. Nowhere is that more evident than with Medicare fees. Overall, Medicare payments to physicians have risen about 1.1% a year on average since 1991—13% less than the increase in physician practice costs. Meanwhile, we work longer hours than we used to, with cardiovascular specialists ranked at or among the top of hours worked and procedures performed.

For cardiovascular specialists, Medicare is our biggest concern. On average, more than half of our patients are Medicare beneficiaries. In fact, cardiologists are more dependent on Medicare than any other medical specialty. And we all know that the remaining third-party payers most often follow Medicare's lead when it comes to deciding how much to pay for an electrophysiology evaluation or a stent procedure. Cardiologists have felt the pinch from Medicare reductions in our overhead practice expenses—that is, the money reimbursed to pay for the day-to-day expenses of running our practices. Because of the practice expense changes mandated by Congress, payments to cardiologists have been lowered by 13% relative to the average Medicare procedure over the last four years. And while cardiologists are treating more patients, that doesn't necessarily mean that it has made up for these reductions.

Medicare reimbursement for new devices and sophisticated procedures being performed in the office is also decreasing. For example, payments for in-office echocardiograms have decreased by 36% since 1998. Even more concerning are the indications from the CMS that it is considering establishing a set price for the use of all devices in a therapeutic category. If that were to happen, there would be an incentive to use the least costly devices, and manufacturers would be less willing or less likely to develop new, advanced devices.

ECONOMIC TREADMILL

Our economic treadmill, it seems, is steepening its incline and picking up speed. The question, then, is what does that mean for physicians and our health care system? First, cardiologists may very well be forced to stop performing more advanced services in their offices. As a result, patients

will have to go to a hospital to have them performed, and the costs to both the Medicare program and the patients will be much greater. Fewer reimbursement dollars will also mean a reduction in available funds for physicians to conduct continuing education, provide their staff with additional training, and make technological improvements such as the computerization of medical records.

Finally, and perhaps most sadly, physicians who are feeling the financial crunch the most or who have just grown tired of dealing with bureaucratic hassles may begin leaving medicine at younger and younger ages. Recent surveys indicate that nearly 40% of physicians 50 years or older plan on retiring within the next three years and that more than 15% plan to significantly reduce their practice or refuse to see new patients.

THE SOLUTION LIES WITHIN

When the fee schedule was released, the American College of Cardiology (ACC) College, along with the AMA and other specialty societies, stormed Capitol Hill to educate lawmakers about the problems presented by the fee schedule reductions. The efforts were tremendously successful, as legislation was introduced to mitigate the problem within weeks. The College then called on its members and urged them to fax letters, make phone calls, and zip off e-mails to their elected officials and tell them to support the bill.

Unfortunately, we ended up on the losing end of the legislative battle. But if you'll excuse another cliché, while we may have lost the battle, we still can win the war. The combined effort it took to get the fee schedule legislation as far as we did in a matter of weeks is a perfect example of how we as physicians and as citizens of this country can effectively use our collective voice. Members of the ACC communicated *en masse* with their elected officials to let them know that they were concerned and that they expected their officials' backing, and they rallied their colleagues to do the same. It was a stupendous effort in the face of overwhelming odds, and regardless of the outcome, I consider it a real victory.

MEMBER INVOLVEMENT

How do we keep the momentum going, though? How do we taper the treadmill's pace and make logical reimbursement policies a right instead of just a wistful hope? The answer, as I have stated in previous President's Pages, is for members to get involved. Members of the ACC, for example, can join the College's Key Contact program and commit to being a strong voice for cardiology with their federal legislators. Beginning next year, members can also contribute to the College's political action committee, or PAC, which is currently in its formative stages. I know that some people think that "PAC" is a derogatory word, but it is a truly effective (and highly regulated) political tool.

On the local level, ACC members can participate in their ACC chapters' government relations programs; if their chapter doesn't have a program, members can help establish one. The College has developed several new grassroots tools—including a "how-to" kit for grassroots advocacy called "Heart of the Matter—A Cardiologist's Guide to Public Policy"—that are freely available on the ACC Web site to assist in such an effort. There are other informational resources on the ACC Web site, and members are encouraged to consult with Advocacy Division staff at Heart House (advocacydiv@acc.org) if they have questions or need assistance with their grassroots efforts. The resources and the incentive are clearly there. Now it's time for action.

We are not taught about being an advocate for our patients or ourselves in medical school. And although it's unfortunate that we must spend valuable time squabbling over reimbursement, it's becoming an increasingly necessary requirement of practicing medicine today. Battling for fair fees is an additional hurdle that we must now face, an extra challenge in the road to caring for patients—remembering that the latter is why we got into medicine in the first place. The question we have to ask ourselves now is whether we're up to the task. Having worked with so many fine physicians over the years, I believe we are. And besides, what choice do we have?

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